

# **Are senior nurses on Clinical Commissioning Groups in England inadvertently supporting the devaluation of their profession? : A study of the literature**

## **Abstract**

This paper discusses the role of senior nurses who sit on *clinical commissioning groups* that now plan and procure most health services in England. These nurses are expected to bring a nursing view to all aspects of clinical commissioning group business (National Health Service England 2014a; Olphert 2014). The role is a senior level appointment and requires experience of strategic commissioning. However little is known about how nurses function in these roles. Following Barrientos' methodology (1998), published policy and literature were analysed to investigate these roles and NHS England's claim that nursing can influence and advance a nursing perspective in *clinical commissioning groups*. Drawing on work by Berg et al (2008, 2014) on 'new public management' we discuss how nurses on *clinical commissioning groups* work at the alignment of the interests of biomedicine and managerialism. We propose that the way this nursing role is being implemented might paradoxically offer further evidence of the devaluing of nursing (Latimer 2014) rather than the emergence of a strong professional nursing voice at the level of strategic commissioning.

*Keywords:* *Clinical commissioning groups*, governing body nurses, commissioning nurses, new public management, leadership, 6Cs

## Introduction

As Rudge (2015) has pointed out, the global economic crisis has seen governments adopting increasingly 'managerialist' agendas. These agendas have tended to further entrench dominant forms of health delivery - namely biomedicine - as well as cuts to funding for health care provision. These budget cuts are couched in the language of efficiency savings and the effective use of resources. Alongside these financial constraints and changes in funding of services, governments in Western Europe have also been concerned with transforming the control of public services (Davies et al 2005; Allan et al 2014) and restructuring the relationships within traditional systems of governance (Saltman 2003). Within this context, the concept of a commissioning board as a governance model for healthcare has emerged in many European systems (Saltman & Figueras, 1997).

The same states have introduced what Berg et al (2008) argue is the 'new public management', the application of private sector managerial techniques in public or state sectors such as education and health; techniques such as performance management; increased surveillance; and regulation through audit for the purposes of governance. In such a system, the professional is moved from a concern with professional values to managerial concerns: 'the work of care management moved from administration to management with implications for professionals and autonomy of care managers' (Berg et al., 2008, 118). Berg et al argue that this change in focus produces tension and conflict for some professionals.

In the UK, the Health & Social Care Act (DH 2012a) introduced a major restructuring of the National Health Service (NHS) in England. This included removing responsibility from government ministers for direct operational management and creating National Health Commissioning Board (since 2013, National Health Service England [NHSE]) - a national commissioning board which devolves responsibility for local commissioning to 211 *Clinical*

*Commissioning Groups* (CCGs) to plan, agree and monitor health and social care services<sup>1</sup>. In 2013, led primarily by General Practitioners or primary care doctors (GPs) representing local GP practices, CCGs took over the design and commissioning of most health services in England on the assumption that commissioning by clinicians would lead to improved decision-making, improved outcomes for patients and more effective use of resources (DH 2011). Indeed CCGs have a legal duty to assure quality across commissioned services in secondary care and, from 2015/16, have additional optional responsibilities including general practice performance management and reviewing GP contracts (Holder et al 2015).

Accountable to the National Health Service England, CCGs are allocated 80% of National Health Service funding and have the authority to direct services in response to local population need. The expectation is that local populations will be included in decisions about healthcare provision (Baldwin and Wilson, 2009). This restructuring in 2013 caused immense unrest and unease across the professions. Pollock and Price (2011) argued that the Health and Social Care Act put in place the legal architecture for a commercial system of care [that in time would be tantamount to the privatisation of the NHS. There were concerns too that CCGs would not be credible, dominated as they were by GPs.

The governing body of each CCG includes a number of statutory roles: a Chair, an accountable officer, a finance officer, two lay members, a clinical member, and a clinical member registered nurse, subsequently known as a governing body nurse. In order to meet the needs of the local population, the commissioning cycle comprises the processes of assessment and planning, implementation and monitoring services, and evaluation (Leach & Burton Shepherd, 2014). The Royal College of Nursing (RCN<sup>2</sup>) successfully argued that nurses could bring unique perspectives and skills to the work of CCGs, and that to promote

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<sup>1</sup> National Health Service England defines commissioning as ‘not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment’ (NHSE 2015).

<sup>2</sup> The Royal College of Nursing (RCN) in the UK is the main professional organisation for nurses and health support workers.

excellence in healthcare, “every CCG must have a nurse on their governing body” (RCN, 2012a, 2). Such nurses were expected to have significant experience in leadership and management (RCN, 2012a).

Governing Body nurses have a statutory role i.e. each CCG is legally required to appoint a governing body nurse. Their role as a governing body board member is different to nurses reporting to the CCG governing body members, such as nurses working in Commissioning Support Unit<sup>3</sup>, nurses working in primary care or in GP practices, e.g. practice nurses, who might be well known to local GPs<sup>4</sup>. The commissioning *and* leadership components of the governing body nurse role were highlighted at a very early point in discussions of these new nursing roles on CCGs when in fact NHSE’s definition of commissioning did not emphasise the leadership role as inherently part of commissioning. What this means is that the GBN’s role is to bring a nursing perspective or leadership, an understanding of nursing (DH 2011, 3.40), and to “promot[e] nursing involvement at every level in the new commissioning structure” (RCN, 2012a, 6). However, as with other senior nursing roles (Burdett Trust for Nursing 2006), concerns have been raised about whether senior nurses including governing body nurses can be effective in advancing a nursing perspective; what such a perspective might be; what the demands of the role might be; and what support needs such nurses might need or be offered

Furthermore, despite the Royal College of Nursing (2012a) advocating strongly that nursing leadership was essential to CCGs achieving their targets in terms of ‘quality, safety, effectiveness and efficiency...successful authorisation and continuing improvement’ (2012a,1), it is unclear what they mean by nurse leadership. For example, in the

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<sup>3</sup> Commissioning Support Units are intended to provide support to Clinical Commissioning Groups by providing business intelligence, health and clinical procurement services and other back-office administrative functions, including contract management.

<sup>4</sup> Practice nurses were widely considered early in 2013 to have been the nurses most likely to be appointed as governing body nurses. But the requirements for these senior roles mean that they cannot work for the same services the CCG commissions from, i.e. the governing body nurse has to have some distance from the service s/he commissions.

multiprofessional, public sector context of the National Health Service, it is biomedicine that has pre-eminence. Moreover the term 'leadership' has become almost synonymous with that of 'management' (Lawler 2005). Generalised management and leadership knowledge in many ways have become more highly valued than specific knowledge and experience (Berg et al 2008). Nonetheless, it is of note that a new three year vision and strategy promoted by NHS England's Chief Nursing Officer, the "6Cs" strategy<sup>5</sup> which sought to embed compassion anew in nursing, includes an aspiration for commissioning nurses to secure "high-quality care for all now and for the future" (NHS Commissioning Board, 2012).

Early evidence suggests some governing body nurses lack the experience necessary to realise the complex and diverse responsibilities they face (NHS Confederation, 2011; West, 2012). In addition, many of these senior nurses express confusion about their job description and describe a lack of managerial support compared to other colleagues (West, 2011). Despite the assertion from the Royal College of Nursing and National Health Service England that the governing body nurse role is a new leadership role which will assert the nursing voice in CCGs, there appears little exploration of how these nurses function at board level on CCGs. Consequently, the ensuing review focuses on the governing body nursing role in CCGs and problematises the Royal College of Nursing and NHS England's claim that a governing body nurse might bring a unique nursing leadership role to the functioning of CCGs. We analyse our findings in the light of Berg et al's account of 'new public management'<sup>6</sup> (Berg et al 2008).

## **The study**

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<sup>5</sup> Following a series of reports that highlighted concerns about poor care, a lack of privacy, dignity, respect and compassion in healthcare delivery, the Chief Nursing Officer for the National Commissioning Board and the Nursing Director at the Department of Health, responded with a strategy where care, compassion, competence, communication, courage and commitment would be embedded as values in health services.

<sup>6</sup> New public management and its reforms are conceived as deliberate policies and actions to alter organisational structures, process, and behaviour, to improve administrative capacity for efficient and effective public sector performance.

This literature study is part of a larger programme of research into the roles of GBNs (see Allan et al forthcoming). Following Barrientos' methodology (1998), published policy and literature were analysed in this study to investigate the GBN role and the claim to influence and advance a nursing perspective in CCGs. The following search terms were used: Governing Body Nurses; *clinical commissioning groups*; nursing leadership; and commissioning nurses. The electronic databases searched were: BNI; CINAHL; ProQuest Nursing and Allied Health; Pubmed; and The King's Fund. The inclusion criteria were: English language; peer reviewed; national; and international journal papers; from 2006 until 2015. In total, 48 papers were retrieved and 36 reviewed. The selection process was based on literature focussing directly upon healthcare and nursing leadership in the context of clinical commissioning, such that more tenuous links in other papers were rejected. The focus of the literature and policy was the United Kingdom. The literature was reviewed fully by two researchers and discussed iteratively within the research team.

Four themes emerged from the literature study: the role of the nurse in CCGs; the selection and preparation for the role; governing body nurses' relationships with practice nurses; and the contested nature of the leadership role of the governing body nurse.

### **The role of governing body nurses**

As early as 2011 (Department of Health, 2011), nurses reported that they had been given insufficient time, training or support to enable them meaningfully to fulfil the duties of a CCG governing body nurse (West, 2011). It was argued (NHSE, 2014b; Leach and Burton Shepherd, 2014) that without adequate preparation and facilitation, the nurse's involvement could be 'tokenistic' (West, 2011). While governing body nurses must have extensive clinical experience (RCN, 2012b; Olphert 2014) there is little research that details what such nurses or other nurses reporting to CCGs do, or what skills they draw upon to be effective (Allan et al., forthcoming). Olphert (2014) asserts that the role of the governing body nurse includes four main areas of activity: quality and patients' experience of care; service redesign and

commissioning care pathways; guardianship of the patient experience across care settings; and safeguarding patient, public and partnership engagement.

Olphert's findings are based on the results of two surveys published by NHS England<sup>7</sup> (2013, 2014) and completed by members of the Commissioning Nurse Leaders Network, a forum comprising 415 members from CCGs, Commissioning Support Units and NHS England, set up jointly by the Royal College of Nursing and NHS England. Their results should be treated with caution as the Commissioning Nurse Leaders Network did not use independent researchers to develop or administer the survey. Nevertheless these results showed that governing body nurses found their role challenging due to its complexity and breadth, and that they expressed uncertainty in their abilities to fulfil the role (NHSE, 2014b). Similarly, although based on anecdotal evidence, Gupta (2012) found nurses felt they lacked the experience to tackle the role.

While the NHS England survey found 84% of respondents reported confidence in their ability to lead the quality assurance agenda (NHSE 2014b), responses also strongly suggested that quality assurance should not just be the concern of GBNs but the responsibility of all clinicians. Nonetheless, Olphert (2014, 412) also found that safeguarding quality assurance, leadership and clinical involvement in the development of commissioning "sit[s] largely" with the chief nurses [GBNs] on CCGs.

Interestingly, the term 'commissioning nurse' is now being used interchangeably with the term governing body nurse (McCann et al 2014). 'Commissioning nurse' used to refer to nurses working in commissioning roles on Primary Care Trusts, the administrative bodies responsible for commissioning the majority of health services which were decommissioned

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<sup>7</sup> NHS England oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the National Health Service in England as set out in the Health and Social Care Act 2012. NHS England comprises around 6,500 staff in 50 sites around England. The bulk of its staff previously worked for the decommissioned Primary Care Trusts and Strategic Health Authorities.

in 2012, before the introduction of clinical commissioning groups. CCGs were launched with a wider role around commissioning than Primary Care Trusts. However the resurfacing of the term 'commissioning nurse', despite the governing body nurse role originally being envisaged as wider than the PCT commissioning role (NHSE, 2015; McCann et al 2014; Olphert 2014), may indicate the assumption of 'business as usual' for the nurse in this role. So at the very least there is some uncertainty over the role of such nurses in leadership and the extent to which this role should extend beyond the original definition of commissioning to include the wider functions Olphert describes and that NHS England (2015) aspires to.

### **Selection and preparation for the role**

On the basis of their survey results, NHS England (2014b) suggests that future development of the governing body nurse role requires careful planning. The Commissioning Nurse Leaders Network survey results suggest that these nurses do not reflect the demographic diversity of registered nurses (NHSE, 2014b) which the Chief Nurse for England (Chief Nurse England Summit 2014) acknowledges in other nursing leadership roles. More generally, as Cavanagh and Chatwick (2005) argue, management and leadership roles are under-taught in pre-registration nursing preparation programmes and students are not encouraged to develop careers in senior roles.

Concern about ineffective role performance has been suggested in the literature arising from governing body nurses having insufficient experience to make a meaningful difference at CCG board level (Carlisle, 2013). This may or may not be related to the deficits in undergraduate curricula. Another concern is the number of governing body nurses working only two/three days a month (Parr, 2012). The Royal College of Nursing warned in 2012 that it would be "less effective to provide [GBNs] on a sessional or back-fill arrangement" (RCN, 2012b). In a pilot study by Allan et al., (forthcoming) governing body nurses expressed mixed views about part-time governing body nurse posts. Effectively there appear to be two 'models' of governing body nurses working on CCGs: a part-time model, where nurses work



on average two sessions per month with a statutory, non-executive function on the CCG board, and a full-time model with an integrated, executive governing body role. The participants in Allan et al's study considered that for the GBN role to be effective, governing body nurses, irrespective of whether full time or part time, 'had to be' leaders. However it was unclear whether these participants were, in practice, primarily leaders of nursing or whether they played a wider leadership role within CCGs.

### **Governing body nurses' relationships with practice nurses**

Practice nurses in England are employed by general practitioners to provide contracted primary health services to a local population; as such they are not NHS employees (RCN 2004). Their career progression to senior management roles is non-existent and their terms and conditions are generally considered to be less advantageous than those of nurses working as NHS employees (RCN 2004). Their knowledge of local population's health is extensive.

Recommendations published by the Royal College of Nursing (2012a, p.3) stipulate that "the [commissioning board nurse] [...] should [not] be a general practice employee". Leach and Burton Shepherd (2014, 188) propose that these two statements are incongruous, questioning "the extent to which the statutory nurse is aware first hand of the local population needs, [if they] have limited recent clinical experience" of that locality. Leach and Burton Shepherd (2014) consider local practice nurses to be an indispensable asset to CCGs. Their work with patients in the community provides essential knowledge of populations, and such nurses therefore serve as conduits to communicate and endorse the aims of the CCG. As Liam Williams (in Carlisle, 2013, 7) highlights:

*[...] many community (practice) nurses are leading the transformation of services. They know how clinical practice can evolve and where independent prescribing can play a part. They are working with specialist*

*nurses and understand the patient pathways and how these can be changed.*

But their relationship to governing body nurses may be problematic. Jeffrey (2012) suggests that the GBN, who by definition is not a clinical nurse practising in the local community but must have extensive practice and managerial experience to be appointed, may provide an obstacle to the voice of the practice nurse being heard in planning local health care services. Essentially arguments over the relative merits of governing body nurses and practice nurses, and their contribution to CCG work, centre on the tension between clinical and managerial credibility. Indeed Latimer (2014) argues that this tension lies at the heart of problems around nursing leadership more generally - especially when the model in which medical leadership is rooted privileges clinical expertise. It may be that the revalidation system being introduced within UK nursing (Nursing & Midwifery Council 2015) will go some way to reconciling the nursing managers' perceived lack of credibility. However the central issue may not be the credibility of governing body nurses as managers or as clinicians but instead their credibility within the profession, given that the credibility of CCGs is questioned more widely (Stirling, 2013). To enhance the credibility of CCGs, Stirling (2013) suggests that the Joint Strategic Needs Assessment (JSNA) could serve as a valuable intermediary between CCGs and GP practices, as the JSNA provides a broad perspective of population needs that affords local GP practices a more comprehensive understanding of their community's needs. The JSNA is a local authority-led initiative, involving a wide range of stakeholders whose objective is to supply a multi-faceted overview of their population's needs to help the commission and provision of health services (NHS Confederation, 2011). Stirling (2013) sees nurses as essential representatives on the JSNA arguing that they potentially bring knowledge of patients and communities whereas doctors may be more narrowly focussed on clinical perspectives. Parr and Wild (2011) consider the possibility that the potential contribution of nurses to the JSNA is underutilised but also argue that there is little evidence that governing body nurses have the skills to succeed in these roles. To combat this perceived lack of skills among these nurses in relation to the JSNA and clinical concerns

more generally, the Royal College of Nursing suggest using non-statutory nurses on a sessional basis to provide valuable information on the needs of a particular patient group (RCN 2012c, 3). In other words, they suggest supplementing the governing body nurse role with the local knowledge of practice nurses and others (see also Trevithick, 2013). In that case, it is unclear to what extent governing body nurses can be said to be leading nurses or providing co-leadership to a local nursing workforce.

Although it is suggested that the governing body nurse in the CCG will be the voice of nurses locally (NHS Commissioning Board, 2012), practice nurses are employed by GPs with different terms and conditions (RCN 2004), they are therefore arguably beyond the influence of governing body nurses. This difficult positioning for both practice nurses and governing body nurses is typified in the way National Health Service England values the practice nurse as advisor whilst also suggesting that governing body nurses should provide a leadership role for practice nurses. However, they say little about how they should go about effecting this leadership role (Trevithick, 2013) particularly when support for governing body nurses to develop leadership is provided by the Commissioning Nurse Leadership Network (Olphert, 2014). What is not clear is whether governing body nurses exerting this leadership may exacerbate local tensions in the already difficult relationships between a) local practice nurses and governing body nurses who are not practising locally and b) between governing body nurses and other community nursing colleagues.

### **The leadership role of governing body nurses**

The Commissioning Nurse Leadership Network offers a framework to “support commissioning nurses as system leaders, to fulfil their leadership potential (Bhardwa, 2014, 16). This framework is grounded in the values of ‘the 6 Cs’ (Cummings and Bennett (DH, 2012). The Commissioning Nurse Leadership Network argues this framework is necessary to deliver the “skilled and compassionate care [that] patients deserve” (p.9). McMann, et al. (2014, 16) also argue that the qualities outlined in ‘the 6Cs’ framework are central to the commissioning nurse role, not specifying explicitly the governing body nurse’s role, but adding that the benefit of having an experienced and senior nurse

leader within a CCG means that issues of “care, compassion, dignity, quality and safety” can become embedded in the commissioning process. This seems, at the very least, ironic given the tensions outlined above around senior nurses’ (including governing body nurses) apparent ‘lack of credibility’ (Latimer 2014). In addition, the extent to which such nursing roles effectively advance ‘the 6Cs’ in commissioning is unknown. Nor is it clear why they should assume sole professional responsibility for advancing them. Moreover, these aspirations are based on several assumptions that go unchallenged. Namely that ‘the 6Cs’ framework (DH 2012c) is compatible with the governing body nurse role or commissioning more widely; that these roles can be described in short hand as commissioning roles rather than the wider roles outlined by Olphert and the NHS England itself; and that the governing body nurse’s leadership role is based on an implicit model of clinical leadership (where governing body nurses may indeed lack credibility) rather than strategic or political leadership (Antrobus & Kitson, 1999).

It is also of note that there is no clarification of what is meant by leadership in the context of embedding the 6Cs in the commissioning process. Berg et al (2008) cite Lawler who argues that the term ‘leadership’ has superseded the term ‘management’ in the public sector, and the terms are not synonymous: ‘leadership’ focuses on change and motivation, ‘management’ on efficiency and regulation (Lawler, 2005). The governing body nurse role and other CCG board member roles may be more about intended management of local public health service redesign rather than leadership as implied in the 6Cs strategy.

Olphert (2014) considers that the challenges facing governing body nurses stem from expectations that they will lead or have influence in a medically dominated environment which crosses acute and primary health care; one in which they lack experience as most have clinical experience in acute care (Leach and Burton Shepherd, 2014). Indeed the NHS England survey of 2014 found that governing body nurses’ top five concerns included working beyond the remit of their expertise and having a limited understanding of the diverse knowledge necessary to enact their role. Leach and Burton

Shepherd (2014) add that such doubts are found to reduce confidence levels and therefore a governing body nurse's belief in their ability to influence and provide leadership.

According to the National Health Service CCG guidelines, all governing body members should "be highly regarded as a clinical leader, beyond the boundaries of a single practice or profession – demonstrably able to think beyond their own professional viewpoint" (NHS Commissioning Board, 2012, 12). However, Trevithick (2013) expresses concern that the historical development of nurses in commissioning (she does not refer to other functions) is limited, and therefore attaining the breadth and expertise to undertake CCG membership, let alone leadership, may prove challenging for them. Trevithick believes that nurses may be preoccupied with reorganisation and managing cost pressures, as was previously reported anecdotally in previous commissioning roles in the health services, rather than with leading nurses in the commissioning agenda, or taking on other leadership roles, including the leadership of non-nurses. Although some CCGs report working successfully in an integrated way (Parr, 2012), what is not reported in the literature is any acknowledgement of the embedded historical power relationships in CCGs (Latimer, 2014). –Unfortunately, observational studies of CCGs at work are lacking but might usefully clarify the nature of these roles and the relationships between them.

The leadership ability of governing body nurses is important given that clinical credibility is a contested area in leadership and management and they are vulnerable to being seen as lacking clinical credibility in the local practices of CCGs. Furthermore their role in leadership does not appear to be validated within CCGs. In an NHS England survey of CCG chairs, chief operating officers and accountable officers (NHSE 2014b), respondents were asked to rate the contribution made by different groups to their CCG's leadership. Ninety-four CCG leaders from 86 CCGs responded to the survey; respondents rated 94 per cent of GP leads and managers as making a 'large' contribution but failed to comment on the governing body nurses' leadership contribution. Somewhat surprisingly then, when asked to self-report their commissioning leadership skills in the same survey, governing

body nurses recorded high confidence and competence in their commissioning and leadership skills (NHSE, 2014).

## **Discussion**

It might be concluded from this review that the governing body nurse role is shaped perfectly legitimately by the interests of the Royal College of Nursing and NHS England to promote a nursing agenda in the commissioning of health services after the re-organisation of the National Health Service in 2012/13 and the introduction of new commissioning structures. The inclusion of the governing body nurse role was a last minute addition to the Health and Social Care Act (2012) due to pressure (mainly) from the RCN. However these review findings suggest that such a role was not well thought out in advance but could be seen as an astute political move. Our findings also suggest that NHS England, in embedding 'the 6Cs' strategy in commissioning (as well as elsewhere in nursing in England at present [Allan et al forthcoming]) seeks to impose a particular discourse of nursing which is congruent with government's concerns around cost containment and governance which would be similar to other European Union states outlined in the beginning of this paper.

Our findings suggest that governing body nurses are in a role that is not clearly defined and for which they often do not have the right skills or experience. They are expected by NHS England to exercise leadership in a context in which nursing is not sufficiently valued amongst CCG colleagues (predominantly GPs) to allow nurses to become recognised as leaders. We have suggested that this is because the dominant form of medical leadership is clinical, which governing body nurses are seen to lack due to their careers as managers. Indeed, we would go so far as to argue that rather than representing the emergence of a strong professional nursing voice at a strategic level, the literature to date suggests that the GBN role may - in practice - represent further devaluing of nursing. To some extent this may be further evidence of the positioning of nursing as a gendered profession (Davies, 1995; Butterworth, 2014; Latimer, 2014; Rudge, 2015). However of particular interest here is the way in which the role of governing body nurse on CCGs has evolved within the context of 'new public management' (Berg et al 2008), and how this form of management has shaped the influence

of these nurses within and beyond the CCG. We would also argue (although this is not the focus of our review) that the impact of 'new public management' on the performance of GPs within CCGs may be equally significant and that if both professional groups are in the thrall of 'new public management', the influence of the biomedical model may be waning.

This is a tension we have noted in the literature on governing body nurses and the emerging conflicts between them and practice nurses. Also there is a lack of public criticality from the nursing office in NHSE around embedding of the 6Cs vision and strategy within commissioning. NHS England and the Royal College of Nursing, as powerful interest groups, appear to endorse the embedding of the 6Cs in the new commissioning structures and hence governing body nurses as leading nursing within commissioning without examining how these roles or how services are shaped by the 'new public management'.

In this context the governing body role has become increasingly synonymous with the previous commissioning roles rather than with other aspects of the role such as patient experience or quality. Berg et al., cite Lawler (2005) to make the point that in new public management systems, leadership (change and motivation) is emphasised more than management (efficiency and regulation) as the term 'leadership' is more acceptable than 'management' to public service ideals. We suggest this reframing of management can be seen in the literature on governing body nurses in the emphasis on leadership rather than on their governance and quality (management) roles.

Interestingly, Butterworth (2014) observes that 'some of those who occupy our most senior nurse executive posts are 'actively aping general management models that embrace secrecy and elitism' (2014, 534) and that nursing leadership in England is enmeshed in a National Health Service which has at heart a 'fiscal fiefdom mentality' which offers little to tackle systemic problems in the National Health Service beyond 'tackling affordability' (2014, 534). He argues that nurse leaders are disconnected from clinical nurses and are perceived as 'unapproachable' (2014, 534). Some of these assertions appear to be borne out by our literature review findings. The development of governing body nurses, is based on a statutory framework which appears to drive a wedge between practice

and leadership and emphasises commissioning and management. This is a bizarre state of affairs for a practice discipline, and one at odds with the medical model of leadership grounded in clinical credibility. However as Butterworth argues (2014), some nurse executives have assumed roles with more regard for organisational reputation and corporate image than professional loyalties. The question we ask here is why nurse executives and, it appears, governing body nurses have accommodated a new public management ethos, and a shift from professional values to managerial concerns?

Latimer's analysis of nursing leadership offers us some insight into how this situation may have developed. She argues that moves over the last 20 years towards a marketised and managerialist health care system have increasingly demoralised nurses and devalued nursing work through the structural reshaping of care. In the case of governing body nurses, this structural reshaping of care has meant that these senior clinicians are involved in CCGs primarily as commissioning nurses whose expertise is managerial. In this sense, the demoralisation of governing body nurses is (using Latimer's argument) the result of a continuing division of nursing managers from nursing practice. We have argued that justifying their work through the embedding of the 6Cs in commissioning, rather than through clinical expertise, avoids the reality of commissioning as a form of new public management. Secondly, the demoralisation of nurses and devaluation of nursing work is the product of devaluing the meaning of care. In the case of governing body nurses, the meaning of care has been devalued through turning a role aimed at "promot[ing] nursing involvement at every level of the commissioning structure" (RCN, 2012a, 6) into one largely without clinical nursing expertise and credibility. So invisible has nursing work in communities become to CCGs, that 'more credible' practice nurses are being brought in to advise them. Latimer asks whether nurses lose power when they move to managerial positions, divided as they are from clinical credibility. We argue that governing body nurses may well suffer from a lack of clinical authority and that the move to 'prop' up their credibility through practice nurses feeding them local intelligence might work to their



disadvantage. This is despite the Royal College of Nursing's and NHS England's claims that the role invests nursing with power through their commissioning role and statutory place on CCGs.

Rudge (2015) argues that nurses 'lack the ability to raise a collective voice to point out the immorality of reductions in health care' provision. Our findings suggest that professional bodies, including the Royal College of Nursing and the Chief Nurse in England, have indeed largely accepted the GBN role and have not attempted to recast it in a different light to that of commissioning and 'leadership'. NHS England survey data shows that by and large, GBNs have assumed their new commissioning roles enthusiastically. Perhaps these interest groups have sought to make the best of a bad job.

### **Limitations of the study**

When evaluating the structure of CCGs that are evolving rapidly in response to change, the extent to which this research can be generalised to reflect current practice across CCGs, or how CCGs may mature in the future, may be limited. In addition, since the discussion is grounded by health policy in England, the research may not reflect international trends, or be of relevance to countries beyond the United Kingdom. However we have chosen to reflect on changes to health systems in England in order to consider issues like new public management, how leadership is understood clinically and in management structures, the continuing influence of biomedicine on nursing/policy which are all equally relevant for an international readership if to varying degrees. We would argue that what is happening in England in the NHS is one example of where commissioning becomes a way of governance, and our paper looks at the tensions this poses for nurses working in a new role.

### **Conclusions**

In general, this review shows that there seems little understanding of how nurses function at CCG board level and how, or even, *if* they exert an influence over CCGs to advance nursing values, as intended in the early aspirations of both the Chief Nurse (England) and the Royal College of Nursing. A significant question is what those nursing values might have to offer

commissioning for populations in GP practices beyond representing the broad aspirations of the Royal College of Nursing or the Commissioning Nurse Leadership Network?

The concerns over leadership may obscure the revaluing of nursing and further demoralisation of nurses. We have argued that the development of the GBN role in CCGs as a result of the introduction of the new public management systems with the Health & Social Care Act (2012) have consolidated models of *nursing* management which are congruent with new public management. Our findings suggest that, while the aim of introducing the governing body nurse role was to promote nursing involvement at all levels of CCG work, there is no evidence that governing body nurses providing a distinctive nursing voice. Instead, the governing body nurse role appears to represent a new form of nursing management or leadership, in which nursing values are reframed as in the 6Cs and used interchangeably with the values of commissioning. This process detaches GBNs from direct nursing experience and thus the clinical credibility used by their CCG peers, allowing historical patterns of marginalising nursing to re-emerge.

Our review highlights a relevant and significant problem for nursing and nurses in England, which is relevant to other health care systems and indicative of the demoralisation of nursing and the devaluation of care (Latimer 2014), and which is evidence of the new public management (Beck et al 2008).

We suggest that NHS England, the Chief Nursing Officer and the RCN need to address the question of what new public management means for nurses and healthcare in the context of a rapidly changing and increasingly marketised NHS.

We agree that there needs to be support for nurses in these new roles but perhaps we need to look upstream at nursing engagement with policy, not least our professional bodies, to draw attention to issues raised and what a nursing leadership might look like in a very different health service. Reconceptualising nursing leadership in commissioning through in-depth observational studies of how nurses bring nursing values to commissioning would be a start.

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